DOCUMENT RESUME

ED 165 393 EC 113 317

AUTHOR Shure, Myrna B.
TITLE Model for Study of Client and Treatment Process in a Community Mental Health Center.
PUB DATE Nov 77
NOTE 7p.; Paper presented at the American Association of Psychiatric Services for Children (Washington, D.C., November, 1977); For related information, see EC 113 316-318

EDRS PRICE MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS *Emotionally Disturbed; Exceptional Child Research; *Mental Health Clinics; Personal Adjustment; *Psychotherapy; Success Factors
IDENTIFIERS *Discharge (From Treatment)

ABSTRACT

The paper reviews client and therapist attributes, treatment factors, and circumstances surrounding discharge from a community mental health center. Among findings cited are that degree of illness at the start of treatment was not a factor in how often appointments were missed; and that for those children judged to need further treatment, termination was most likely to be a family's decision and least likely a mutual one. (CL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED165393

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

Model for Study of Client and Treatment Process in a Community Mental Health Center

Myrna B. Shure, Ph.D.
Hahnemann Community Mental Health/Mental Retardation Center

Presented at the American Association of Psychiatric Services for Children
Washington, D.C., November, 1977

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Myrna B. Shure
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

I'm going to talk about various client and therapist attributes, the treatment process, and circumstances surrounding discharge in the 5 outpatient services at the Hahnemann Community Mental Health/ Mental Retardation Center. It was intended as a first step in a series of attempts to delineate those parameters most significant in effective psychotherapy at the center.

With Dr. Siegel having identified and defined the variables and the subject population studied, I am going to first tell you about the relationship of some of the process and client variables.

Interestingly, we found that while children who tended to be in therapy longer (longer length of stay) also had more actual sessions with the therapist, but those who had the longest length of stay also tended to be seen less often, and this was true regardless of how many sessions they had. How can this be interpreted? Perhaps if children who were in therapy longer were seen less frequently than those in therapy a shorter period of time, it is possible that therapy was terminated sooner for those seen more, rather than less, often. It is also possible that those seen less frequently required longer periods of therapy than was true of those seen more often early in the treatment process. It was even possible that (relative to later periods), the early period of therapy was characterized by

EC113117

a higher frequency of treatment. To test this possibility, an independent sample of active patients in treatment for at least four months was examined, comparing the number of sessions held in the first two months with those held the last two months of treatment. Comparison of the mean number of sessions in these two time periods indicated that such was not the case. Therefore, the finding that the longer they stayed, the less frequently they were seen cannot be explained in terms of a pattern of care. It is reasonable to assume then, that clients with a shorter length of stay were seen more frequently than those with a more extended period of treatment, and that this is not explainable on the basis that, in general children and/or their families are seen more frequently during initial sessions.

We also found that Length of Stay, Number of Sessions and Density of Treatment, that is, how frequently the child was seen did not significantly differ between older and younger children, or between boys and girls. How long the child was in treatment or how frequently he or she was seen did not appear to be a function of how severely the child was impaired, though our analyses do suggest the possibility that youngsters coming into treatment more impaired were seen more times than those initially less impaired.

Also, there was no relationship between the percentage of broken and cancelled appointments and the child's initial impairment level, suggesting that degree of illness at the start of treatment was not a factor in how often appointments were missed. We also found appointments were not cancelled or broken because the child was coming for treatment more often.

We then looked at how these variables related to the discipline of the principal therapist, that person who saw the child the most.

With regard to client variables and therapist discipline, we found no significant relationships between sex of the child and principle therapist discipline, indicating a random assignment of boys and girls to psychiatrists, psychologists, social workers, and mental health workers and technicians. The same was also true for age of the child. Each therapist group saw about an equal number of older and younger children.

With regard to how impaired the child was at intake, the least impaired children tended to be randomly assigned to different therapist groups. There was a tendency for mildly impaired youngsters to be seen mostly by mental health workers and mental health technicians as well as psychiatrists, while the moderately to severely impaired tended to be assigned more to psychologists.

About the discipline of the principal therapist, we also found that how frequently a child was treated (Density), how long he or she stayed in treatment (Length of Stay), and how many face-to-face sessions the child had (Number of Sessions) as well as the percentage of broken and cancelled appointments made were not a function of who the child saw, that is; what the discipline of the principle therapist was.

Now I'm going to tell you briefly about discharge variables. Whether a child was judged by his principle therapist to need further treatment was consistent with those decision it was to end it. For those judged to need further treatment, termination was most likely to be a family's decision, and least likely a mutual therapist-family or therapist-client one. Among those not judged to need further treatment, the decision to terminate therapy was primarily a mutual one, more so than <u>just</u> the therapists, or just the client and/or his or her family's.

There was also a significant relationship between degree of impairment at discharge and decision to discharge. A therapist or mutual decision to discharge was primarily for those least impaired. On the other hand, the client's or family's decision to withdraw was not a function of final impairment level, interesting in light of the previous findirgs that many families who withdrew were also judged by the therapist to need further treatment. Also, judgment of need for further treatment was greater among the more highly impaired, and highlights the relationship between discharge impairment level and judged need for further treatment.

Next, we learned that whose decision it was to discharge the patient did not depend on "investment" of the patient and/or therapist in the treatment, as no significant relationship emerged between intensity (frequency) or treatment and decision to discharge.

An interesting possibility was revealed by further analyses. The lowest percentage of broken and cancelled appointments were made by those discharging under mutual agreement. Because the percentage of broken and cancelled appointments did not relate to any other variable studied, this could be a chance finding. However, it is also possible that a low percentage of broken and cancelled appointments reflects a positive attitude or mutuality of feeling between the client and/or his family, and the therapist.

Curiously, however, a therapist's judgment of whether a child needed further therapy was not determined by how long the child had been coming, how often, or how many times he or she was seen. Our data also suggested that the psychologists, in contrast to the other groups tended to be slightly more involved in therapist or mutual decisions. Finally, no one principal therapist discipline stood out as having judged clients as needing treatment, suggesting this

judgment was not a function of how was treating the child.

Now I'll try to put this all into perspective. With regard to the nature of care, professional and non-professional therapists, despite differences in training and experience, did not differ in how long they retain clients in treatment or in the intensity or their work as measured by frequency of sessions. Of the professionals, psychologists tended to see relatively more of the more psychiatrically impaired clients. Psychologists also tended to get more involved with the client regarding the decision to terminate treatment than do therapists representing other disciplines.

We also learned that the child outpatient services at our center offers a predetermined structure of care within which the therapist/client treatment evolves. The number of sessions delivered and the intensity of the work is not significantly affected by level of initial impairment of the child or who does the treatment. Age, sex and initial impairment do not significantly impact the structure within which therapeutic care develops. The mode or norm of therapeutic activity evidences a consistency from case-to-case, relatively independent of the obvious attributes of the particular child or therapist. Most children and/or families are scheduled to be seen about once a week; few are scheduled more frequently, and many are seen less frequently (in part due to broken and/or cancelled appointments). It was learning about these factors that helped us define the natural constraints within which future attempts to study process and outcome of therapy in these units will operate.

But most importantly, the fact that we were able to get consistent and sensible relationships from computer printouts is most encouraging. Though we will be telling you about our present study later, which does involve more personal contacts with unit staff, this study

(including that phase of which Dr. Siegel spoke, and the next phase of which Ms. Sheinfeld will address) allowed us to gather information with no intrusion on unit staff time. They filled out these forms anyway for the county, the state, the federal government and for internal reports. This technique clearly provided a fruitful and convenient way to find out important information (at least at a specific point in time) about what's going on the child outpatient services at a community mental health center.